SECTION 9
ORTHODONTICS

Orthodontic procedures are covered as expanded HCY, Healthy Children and Youth, services. Medically necessary orthodontics is available to all Medicaid eligible patients under the age of 21 with the exception of those patients with ME code 76. These services do require prior authorization (PA) and are only approved for the most handicapping malocclusions. Assessment of the most handicapping malocclusion is determined by the magnitude of the following variables:

- Degree of mal-alignment
- Missing teeth
- Angle classification
- Overjet
- Overbite
- Openbite
- Crossbite

Comprehensive orthodontic treatment is available only for transitional mixed (dentition) or full adult dentition. Exceptions to this policy are granted only in cases of cleft palate or severe facial anomalies where early intervention is in the best interest of the patient. Comprehensive orthodontic treatment includes, but is not limited to:

- Complete diagnostic records and a written treatment plan;
- Placement of all necessary appliances to properly treat the patient (both removable and fixed appliances);
- Removal of all appliances at the completion of the active phase of treatment;
- Placement of retainers or necessary retention techniques;
- Adjustment of the retainers and observation of the patient for a proper period of time (approximately 18-24 months).

Extractions are not included in the fee for the orthodontic treatment but are separately covered under the Dental Program.

Requests for orthodontic treatment are assessed by using the Handicapping Labio-Lingual Deviation (HLD) Index. When submitting a PA request, the provider must include complete orthodontic records and a written treatment plan. Providers must label the orthodontic records, which must include at a minimum, the provider's name or number and the patient's Medicaid/MC+ ID number. If the models and/or x-rays are unusable, they are rejected and new records must be submitted prior to authorization of treatment. The PA request, along with the required records and treatment plan, must be mailed to:

Infocrossing Healthcare Services, Inc.
P.O. Box 5700
Jefferson City, MO 65102

Upon receipt of an approved PA, the provider must verify the patient's Medicaid eligibility prior to beginning orthodontic treatment. It is important the patient's eligibility be verified each time a treatment/service is rendered. The approved PA will state the length of treatment authorized, i.e., 24 months, as well as the total dollar amount authorized for the duration of the treatment.

Payment for the initial phase of a comprehensive orthodontic treatment program may occur after the initial banding has been completed. The initial fee is based on one-fourth of the total approved amount. This fee includes the orthodontic examination, preparation of the necessary dental records, determining the diagnosis, a written treatment plan and placement of appliances. The date of service for the initial payment is the date of banding.

Providers must bill subsequent payments on a quarterly basis. The amount of the quarterly payment is determined by the balance due after the initial payment has been deducted from the prior authorized amount. The remainder is divided by the total number of months treatment was authorized, and the result multiplied by three. This dollar amount represents the amount of all future quarterly payments with the date of service being the last day of the month of each quarter following banding.

Example:
Provider is authorized $2,000.00 for a 24-month treatment plan. The patient is banded on October 26, 2003. The initial claim will be submitted with a date of service of 10/26/03 and a dollar amount of $500.00. To determine the date of the first quarterly payment, the month the patient was banded is counted as month one, therefore, the date of service for the first quarterly payment in this example is 12/31/03. The quarterly payment amount to be billed is $187.50: $1,500.00 divided by 24 = $62.50; $62.50 x 3 = $187.50. The date of service for the second quarterly payment is 03/31/04; the third, 06/30/04; the fourth, 09/30/04, etc. The quarterly payment billed remains the same.

If a patient is only eligible for one or two months of the quarter, the provider must bill the exact dates the patient was seen in the office. Each month must be billed on a separate line and the allowed amount for each month is one-third of the quarterly payment.

If the patient's eligibility ends prior to the last day of the quarter, but after the patient is seen in the third month of the quarter, the last date of eligibility during the third month of the quarter is the date of service.